AGREEMENT TO COMPENSATION BETWEEN THE DEPENDENTS OF DECEASED EMPLOYEE AND EMPLOYER

State Form 18875 (R / 9-87)

INDIANA WORKER'S COMPENSATION BOARD
Room 601 State Office Building
100 North Senate Avenue
Indianapolis, Indiana 46204

Privacy Notice: This agency is requesting disclosure of employee's Social Security Number in accordance with I.C. 22-3-4-13.

Federal Identification Number	Employer Name		Board Number
Social Security Number	Employee Name	Date of Injury / Illness	Date of Death

AGREEMENT STATEMENT

We, the undersigned being all the dependents of the deceased employee who are entitled to compensation under the provisions of the Indiana Worker's Compensation / Occupational Diseases Act due to the death of this employee resulting from an injury / illness arising out of and in the course of their employment and said employer, have reached an agreement in regard to compensation.

The terms of this agreement are:

That the employer shall pay to the following dependents, in equal shares, a weekly compensation of $ _____ , based on an average weekly wage of $ _____ , beginning on the _____ day of _____ , 19 _____ , and to continue during the dependency of any one of them, not exceeding, in the aggregate, five hundred (500) weeks. The employer shall also pay the reasonable and necessary medical expenses incurred as a result of the injury / illness together with the statutory burial expenses of $ _____ of said employee.

DEPENDENTS OF DECEASED EMPLOYEE

NAME	AGE	RELATIONSHIP	WHOLLY OR PARTIALLY DEPENDENT	ADDRESS

Remarks:

Signature of Dependent	Date Signed	(For Board Use Only)
Signature of Parent / Guardian for Dependent	Date Signed	
Signature of Employer	Date Signed	
Signature of Insurance Company Representative	Date Signed	
Name of Insurance Company	Date Signed	